Tuberous Breasts: A Periareolar Approach

According to the authors, this periareolar approach for correcting the tubular breast is especially effective in preventing recurrence. Maneuvers include transecting the constrictive ring, filling the generally hypoplastic inferior quadrants, and redistributing the glandular tissue over the breast base, correcting the constriction that is transversely and/or vertically present. The procedure is easily performed and may also include implant placement. (Aesthetic Surg J 2005;25:398-402.)

Tuberous breast, which is so-named because of its resemblance to a tuberous plant root, may be considered the most severe and most typical form of breast base anomaly. It is especially challenging to correct because of its tendency to recur. Dinner, who considers tuberous breast a syndrome, describes its characteristics as follows: (1) hypertrophy of the nipple-areola complex; (2) pseudoherniation of the breast content into the areola; (3) hypoplasia with commonly-related contralateral side asymmetry; (4) vertical constriction with reduced superior-inferior diameter; and (5) a constricted transverse base.

Many techniques developed to treat this condition have yielded poor results. The simple attempt to remove a doughnut-shaped piece of skin from the areola, with telescoping of breast tissue inward and reduction of areola diameter, does not correct the deformity. Treatment by simply inserting an implant accentuates the deformity, creating a second crease and dropping the entire gland over the implant.

To correct the tubular breast, it is necessary to transect the constrictive ring that is present in the gland. Our technique addresses this challenge with the creation of an inferiorly-based glandular flap. The procedure is easily performed and may also include implant placement. The results have been aesthetically pleasing and long-lasting.

Technique

The most significant element in the technique is creating the glandular flap and positioning it in the thoracic wall. The 3 requirements for correction of this deformity are: (1) transecting the constrictive ring; (2) filling the inferior quadrants that are generally hypoplastic; and (3) redistributing the glandular tissue over the base of the breast, correcting the constriction that is present transversely and/or vertically.

- Since the areola is frequently enlarged, resection of excess tissue is mandatory. Deepithelialize the tissue, preserving the dermal plexus.
- Then divide the mammary gland in half with an incision that is perpendicular to the pectoralis muscle and inferior to the areola. The upper half will contain the areola; in the lower half, you will create the inferior flap.
- To create the inferior flap, free the lower half from its skin with scissors, taking care not to injure the overlying skin and not to leave it too thin. Free the lateral and medial extremities of this flap from the fourth and fifth intercostal vessels. Finish the flap by resecting the medial and lateral extremities. The incision dividing the gland in half and the creation of the inferiorly-based flap account for the disruption of the constrictive ring.
- To create the inferior flap, free the lower half from its skin with scissors, taking care not to injure the overlying skin and not to leave it too thin. Fix the medial and lateral extremities of the thoracic wall, preserving the central attachment. Preserve the perforators from the fourth and fifth intercostal vessels. Finish the flap by resecting the medial and lateral extremities. The incision dividing the gland in half and the creation of the inferiorly-based flap account for the disruption of the constrictive ring.
- Begin to mount the breast by fixing the flap on the thoracic wall. Fix the distal end of the flap inferiorly to its base, bending it over itself, using nonabsorbable sutures, and making it spread over the base. This is an important step, since this will provide for breast projection and fill the lower breast quadrants, which are generally hypoplastic. The upper segment of the breast will fall naturally over...
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the inferior flap, causing the mammary base to become enlarged.

- Make the final periareolar suture using the technique of Peled and Benelli, also called the round-block. In patients with severe hypomastia, you can insert a silicone implant with no significant change in the operative technique. Place the silicone implant in the space between the superior part of the breast and the inferior flap. Close this space using sutures from the superior part to the inferior flap.

Discussion

The abundance of techniques available in the literature for correcting the tuberous breast attests to the great challenge of treating this deformity. The periareolar approach with deepithelialization of the excessive areola and its closure with a round-block suture, as innovated by Benelli, are common to various techniques.

The main feature of our technique, and what separates it from others, is prevention of recurrence by dividing the...
gland in half and creating the inferiorly based glandular flap. Both of these maneuvers account for the disruption of the constrictive ring. Positioning the glandular flap inferiorly to its base, and bending it over itself in a 180° turn, redistributes the tissues over the base of the gland, fills the lower quadrants that are frequently hypoplastic, and corrects the asymmetry of the mammary sulcus. The accommodation of the superior half of the breast over the fixed flap also contributes to the enlargement of the breast base.

Vascular flap impairment, which is a frequently raised concern, was not a problem in our series of 68 patients. The arterial perforators that nourish the flap proved to be constant and reliable. Neither total nor partial flap necrosis was seen.

In terms of the hypoplastic component of the deformity, since Brazilian women prefer having small breasts, this is not an important aspect of the correction for us. However, in the more severe cases, it is possible to insert an implant without significantly changing the surgical procedure. Our technique has successfully corrected this
deformity with pleasing aesthetic results and no recurrence (Figures 1, 2, and 3).

References


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